STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	005002	A. BUILDING: _____ B. WING _____	04/14/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
METHODIST HOSPITALS INC	600 GRANT ST GARY, IN 46402

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
S 000	INITIAL COMMENTS This visit was for the investigation of one State Hospital complaint. Date of survey: 04/14/2015 Complaint number: IN00157690 Unsubstantiated; lack of sufficient evidence. Facility: 005002 Methodist Hospitals, Inc. is in compliance with 410 IAC15-1.5-2, Infection Control and 410 IAC 15-1.5-6, Nursing Service, Hospital Licensure Rules. QA: cjl 05/01/15	S 000		